PI - Full Review Process

Purpose:

To provide instructions for initiation of a full review upon approval of the Investigator's determination to initiate a full review is obtained.

Identification of Roles:

IME Program Integrity (PI) Unit—conduct full reviews as determined to be appropriate.
IME CORE – OnBase assistance as needed

Performance Standards:

Initiate Investigations within one business day of receipt

Path of Business Procedure:

Conducting a Full Review

Step 1. The Investigator gathers information from all available sources such as MMIS, Internet searches, ISIS, etc.

Step 2. If it is determined that the provider had a previous review, the Investigator locates the case file and evaluates it. Documentation in OnBase for the previous review also should also be reviewed.

Step 3. The Investigator identifies the contact log number in OnBase, and then retrieves all Program I documents for this contact log through the Document Retrieval function.

Step 4. The IME CORE Unit publishes user documentation and training materials for OnBase. Contact the IME CORE Unit Account Manager if necessary.

Step 5. Identify a timeframe for the review.

a. The review timeframe chosen will coincide with dates identified in the referral, SUR Subsystem Reports, or the Data Warehouse reports or queries that triggered the investigation.

b. If actual recoupment (for example, a coding error), the timeframe is up to five years, the length of time that the provider is required to maintain records (for maximum recoupment).

c. If the review timeframe is unclear, consult with the Account Manager or Operations Manager to determine an appropriate timeframe.

Step 6. Identify the type of data analysis needed as determined by the purpose of the investigation.

a. Utilize SURS Subsystem Reports related to the provider type or treatment, if appropriate for the review.

b. Request additional data from the Data Warehouse. (Refer to Data Requests procedure.) Data Warehouse information is more easily manipulated and mined for specific queries than is the SURS subsystem, especially when utilizing DBxtra.

Step 7. Review data for information relevant to the case.

a. The Database Management Administrator ensures that only final claims are included in the selected population of claims.

Step 8. Review Medicaid policy, and Federal and State regulations, as applicable.

a. As potential issues are identified, document the issues, along with specific policy and regulatory references (Directory of Codes and Issues).

b. Discuss issues with policy staff responsible for the given provider type and/or waiver staff involved with the provider type to determine what particular concerns or issues may be relevant to the review. Provider Services, Member Services and Medical Services staff have information relative to provider types and review foci. Collaborate with the Account Manager and Operation Manager to determine what other departments should be consulted or kept apprised of provider reviews.

Step 9. Conduct review of the records received from the provider.

a. Research general and specialty-specific billing and coding guidelines to ensure compliance.

b. Review for the following potential documentation discrepancies.

1. Duplicate billing
2. Diagnoses not supportive of the services provided
3. Inappropriate use of modifiers
4. Services provided after the member's date of death
5. Unusual or inappropriate quantity of services provided
6. Inappropriate diagnosis and procedure code use
7. Dates of service prior to provider enrollment date
8. Inappropriate number of units billed
9. Billing services outside of the normal provider specialty
10. Unusual or unexplained billing irregularities

c. As potential issues are identified, document them along with specific policy and regulatory references (refer to "Identifying Case Issues and the Supporting Codes").

d. With Operations manager approval discuss issues with Policy staff responsible for the specific provider type and/or Waiver staff involved with the provider type to determine which particular concerns or issues may be relevant to the case. Provider Services, Member Services and Medical Services staff may have information relative to provider types and review foci. Collaborate with the Supervisor to determine which other departments should be consulted or informed of provider cases.

e. If fraud is apparent or suspected, a referral is made to the Medicaid Fraud Control Unit (MFCU) using the appropriate referral form. All cases with questionable fraud or abuse must be reported to the Supervisor and Account Manager. Refer to the procedure titled "Referral to MFCU." 42CFR 455.2 definition of fraud is intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Step 10. Continue to enter the information gathered during the investigation process into the IME PI Database, for example the date letters are sent. Additional information would include any communications with the identified provider or recipient.

Step 11. Present the review findings for discussion with the Operations Manager or the Account Manager as needed.

a. PI will consult with appropriate Medicaid program staff either in the regularly scheduled bi-weekly meetings with Medicaid Policy staff or on an ad hoc basis, as appropriate.

Step 12. Initiate a Preliminary Report of Tentative Overpayment letter. (Refer to Procedure for Preliminary Report of a Tentative Overpayment.)

a. With this letter enclose the correlating spreadsheet that states the tentative overpayment amount and issues identified.

b. The reevaluation referenced in the letter will be completed if one is granted and the supplemental documentation was received within the required timeframe.

Step 13. When the 30-day timeframe for submission of records has expired, or upon completion of the reevaluation, a Finding and Order of Repayment Letter is initiated. (Refer to Procedure for Findings Letter, Initiating.)

a. Select the appropriate Finding and Order for Repayment template.

Step 14. Refer to "Review Follow-Up" procedure to closure (Level 5 in the PI Database).

Forms/Reports:

\\dhsime\imeuniversal\Operational Procedures\Program Integrity\Forms and Letters\Approved Letter Templates\Other Letters\Referral Information.doc

RFP Reference:

6.1.2.3.13
6.5.2.5

Interfaces:

Program Integrity Unit
State Policy
Medicaid Fraud Control Unit (MFCU)

Attachments:

None